STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185160	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COUNTRY PLACE	700 MASON HEADLEY ROAD LEXINGTON, KY 40504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated survey investigating complaint ARO KY 0002386 and ARO KY 00023860, was initiated on 09/30/15 and completed on 10/01/15. The allegation was unsubstantiated for ARO KY 0002386 with no deficiencies cited and ARO KY 00023860 was unsubstantiated with deficiency cited.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy, it was determined the facility failed to provide an environment that was free from hazards over which the facility had control for one (1) of four (4) sampled residents, (Resident #1) and one (1) Unsampled Resident (Unsampled Resident A). Licensed Practical Nurse (LPN) #1 had administered Oral Morphine to Resident #3 and left the unsealed portion of the bottle in Resident #3 room unsecured and accessible to Resident #1 and Unsampled Resident A. The findings include Review of facility policy, titled "Controlled	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/27/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Substances Management" dated 06/01/10, revealed all controlled substances for residents will be dispensed and maintained according to all state and federal laws. Medications contained in schedule V (five) must be stored in a secured and double locked area.

Review of Physician Orders for Resident #3 revealed an order for Morphine Sulfate 20 MG/1 ML by mouth every four (4) hours around the clock.

Review of the Medication Administration Record (MAR) for Resident #3 revealed the Oral Morphine had been given on 09/20/15 for 10:00 PM.

Record review of the Controlled Drug Record revealed on 09/20/15 at 9:00 PM revealed the Oral Morphine had been signed out for Resident #3. Further review revealed the medication count for the Oral Morphine at 2300 during shift change the medication was missing.

Record review of an incident report dated 09/21/15 revealed LPN #1 contacted the House Supervisor concerning a missing bottle of Morphine immediately at the start of medication count at shift change on 09/20/15 at 11:00 PM. LPN #1 had provided Resident #3 with his/her scheduled dose of Oral Morphine at 9:00 PM. All staff on the unit was not allowed to leave and a search was made of the unit. The House Supervisor notified the Administrator, and Director of Nursing (DON). The Administrator and DON began the investigation and questioned all staff and took their statements. The police were called and State Registered Nursing Assistant (SRNA) #2 was acting out of character. She left the

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building when the police pulled up to the facility. The search for the oral Morphine was continued over several days and was not found.

Review of the medical record for Resident #1 revealed the facility admitted the residnet on 05/18/15 with diagnoses which included Cancer, Arthritis, Low Back Pain and Hard of Hearing. The Annual Minimum Data Set (MDS) dated 07/10/15 revealed a Brief Interview of Mental Status Score (BIMS) of fifteen (15), indicating no cognitive impairment. Review of Section G, Functional Status of the MDS revealed the resident had a wheel chair and required one (1) assist for locomotion on and off the unit.

Review of medical record for Resident #3 revealed the facility admitted the resident on 06/09/15 with diagnoses which included Dementia, Depression, Anxiety and Cardiovascular Accident. The MDS for Significant Change dated 06/15/15 revealed a BIMS score of nine (9) indicating cognitive impairment. Review of Section G Functional Status revealed the resident has a wheel chair and needs one (1) assist for locomotion on the unit. Resident #3 and Resident #1 reside in the same room.

Review of medical record for Unsampled Resident A revealed the facility admitted the resident on 08/10/15 with diagnoses which included Dementia, Hypertension, and Osteoarthritis. The Annual MDS dated 09/07/15 revealed a BIMS score of three (3), indicating cognitive impairment. Review of section G, Functional Status revealed the resident had a wheel chair, cane and could ambulate with assist of one.

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Interview, on 10/01/15 at 5:00 PM, with LPN #1 revealed she had gotten the Oral Morphine out of the Narcotic box and took the medication into the room. She drew up the amount to administer and gave it to Resident #3. Unsampled Resident A was up in his/her wheel chair in the hall way and was directed to return to bed. She thought she had replaced the medication back into the Narcotic box in the medication cart. She did not know that the medication was missing until the medication count at shift change. She stated she had administered the medication on 09/20/15 at 9:00 PM and the medication was found missing at 11:00 PM, at shift change. She notified the House Supervisor immediately and started to search in Resident #3 room for the Morphine.

Interview, on 10/01/15 at 5:15 PM, with LPN #6 revealed she had started medication count at shift change with LPN #1 on 09/20/15. She stated the Narcotic box was counted first, at 11:00 PM shift change and found the Oral Morphine was missing. LPN #1 called the House Supervisor immediately and started to search for the medication. She stated State Registered Nursing Assistant (SRNA) #2 was very nervous and wanted to leave the unit, and was talking on her cell phone.

Interview, on 09/30/15 at 4:00 PM, with House Supervisor revealed she was called at 10:55 PM to the unit concerning the missing Oral Morphine. She instructed staff, not to leave the unit. She searched for the missing medication and contacted the Administrator and Director of Nursing (DON) when the medication could not be located. She stated SRNA #2 was acting strange and wanted to leave. The police were called and the House Supervisor provided the police with a

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statement.

Interview, on 10/01/15 at 10:30 AM, with the DON revealed she was notified by the House Supervisor and Administrator on 09/20/15. She came into the facility with the Administrator to start the investigation. All staff statements were taken in the lobby conference room. Multiple searches were made over many days for the medication. The consultant pharmacist conducted inventory and did not find any other missing narcotic in the facility. The Policy for any medication to be prepared at the medication cart and the Narcotic should have been locked up. She stated the medication left out posed a hazard to the residents.

Interview, on 10/01/15 at 1:00 PM, with the Administrator revealed she was notified by the House Supervisor on 09/20/15. She called the DON and they both arrived together at the facility to start the investigation process. They assisted with the search for the missing medication. Staff was brought to the lobby area to get their statements and the Police were called. The police arrived and SRNA #2 left the building. LPN #1 and SRNA #2 were both terminated. She stated all medication should be drawn up at the medication cart and not left in the residents' room. The Oral Morphine could be a potential hazard to other residents and could be harmful.